Fact Sheet

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Community Care

Medical Document Submission Requirements for Care Coordination

The Department of Veterans Affairs (VA) requires the submission of all community care medical documentation to VA. Documentation of care purchased in the community is critical to care coordination by OCC staff. Documentation in support of care coordination must be submitted promptly after services are rendered. The submission of claims for services and any documentation required to support claims processing activities falls outside the scope of care coordination.

The table below serves as a guide as to what documentation should be submitted for care coordination purposes, based on the type of service provided. The documentation types under each category are considered clinically relevant for care coordination and should be submitted unless it is not applicable to the care that was provided (for example, a primary care visit may only include the progress note if no ancillary services were performed). Additional documentation may be added to the list by VA facilities wishing to include specific documents, but documents currently identified below may not be removed.

Service	Documents
Primary Care	• Progress Notes • Summary note of care when patient no longer requires further treatment • Ancillary Services, if performed (Results) – Radiology – Laboratory
Inpatient Care - Medical (i.e., Acute Inpatient)	• Progress Notes • Discharge Summary • History and Physical • Consultations • Diagnostic and Therapuetic Procedure Report, if performed (Results) – Radiology – Laboratory • Transfer note/summary if used in lieu of Discharge Summary • Discharge Medications • Legal documents, i.e., Advance Directive, Living Will, Power of Attorney, Guardianship • State Authorized Portable Orders • Do Not Resuscitate (DNR) or Do Not Attempt Resuscitation

Service	Documents
Inpatient Care - Surgical	• Progress Notes • Discharge Summary • History and Physical • Operative Report • Consultations • Diagnostic and Therapuetic Procedure Report • Anatomic, Surgical and Cytology Pathlogy – Should be received within 48 hours • Transfer note/summary if used in lieu of Discharge Summary • Discharge Medications • Legal documents, i.e., Advance Directive, Living Will, Power of Attorney, Guardianship • State Authorized Portable Orders • Do Not Resuscitate (DNR) or Do Not Attempt Resuscitation (DNR)
Inpatient Care - Mental Health	• Progress Notes • Discharge Summary • History and Physical • Consultations (if performed) • Ancillary Services, if performed (Results) – Radiology – Laboratory • Transfer note/summary if used in lieu of Discharge Summary • Discharge Medications • Legal documents, i.e., Advance Directive, Living Will, Power of Attorney, Guardianship

Service	Documents
Community/Contract Nursing Home (CNH) (e.g. Community Living Centers (CLC), Community Nursing Homes (CNH))	**Transfer from CNH to VA Facility** • Discharge Summary • Transfer Summary if used in lieu of Discharge Summary • History and Physical • Procedure Notes, if performed • Operative Report, if performed • Ancillary Services, if performed (Results) – Radiology • Laboratory • Discharge/Transfer Medications **Veteran Death at CNH** • Discharge Summary • Death Certificate
State Veteran Homes **Note:** For health records located at the SVH, VHA Handbook 1601SH.01, State Veteran Home (SVH) Per Diem Payment Program, states that policies and procedures for the content, filing, and retention of health records are managed by the SVHs in accordance with the State law.	• State Home Program Application for Veteran Care Medical Certification (VAF 10-10SH) • Any other supporting documentation submitted **Veteran Death at SVH** • Discharge Summary • Death Certificate
Ambulatory Surgery	• History and Physical • Procedure Notes • Operative Report • Anatomic, Surgical and Cytology Pathlogy – Should be received within 48 hours
Emergency Room (ER) Care	• Emergency room note • Treatment Plan • Transfer note/summary (Point of stability for transfer) • Discharge Instruction • Ancillary Services, if performed (Results) • Radiology • Laboratory • Discharge medication, if precribed **Veteran Death at ER** • Discharge Summary

Service	Documents
Specialty/Outpatient Care	• Mammography Report (including BI-RAD) • Progress Notes/Consult Report • Summary note of care when patient no longer requires further treatment • Ancillary Services, if performed (Results) • Radiology • Laboratory • Discharge medication, if precribed
Observation	• History and Physical • Discharge Note/Instructions (including Discharge Diagnoses) • Discharge Medications
Outpatient Mental Health	• Summary note of care when patient no longer requires further treatment • Treatment Plan • Discharge medications, if prescribed
Urgent Care	• Urgent Care Note • Treatment Plan • Ancillary Services, if performed (Results) • Radiology • Laboratory • Discharge medication, if prescribed
Administrative Documentation	• Advance Directives • Living Will • Guardianship

For additional questions please email OCCHIMCONTACTS@va.gov.